Substance Use Documentation Training

Purpose

- Hello!!
- Merced County Behavioral Health and Recovery Services (SUD) services to adults who have a substance use disorder and to adolescents who have or may be at risk of developing a substance use disorder.
- The purpose of this power-point is that Merced County has opted in to participate in the State's Drug Medi-Cal Organized Delivery System (DMC-ODS), which allows greater coordination of care for clients as they move from one level of care to another, thereby increasing the likelihood of successful treatment outcomes.

Disclaimer

- This manual is a living document and will be amended as needed, based on changes made by the State as well a any internal program requirements implemented. Please keep in mind that the State sets a minimum requirement and the County can impose standards above and beyond the State's guidelines. This version is based on the current understanding of the State regulations as well as the County's agreement with the State on what will be provided.

Medical Necessity

- This is the foundation on which all treatment rests. According to the DMC-ODS standards, clients must meet the following Medical Necessity criteria:
  1. Must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance related disorders.
  2. Must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria.
  3. If applicable, it must meet the ASAM adolescent treatment criteria.

Medical Necessity….

- **SO….for the purposes of our initial intake, it is not enough to gather information about the clients' life. IT MUST BE DIRECTED AT IDENTIFYING HOW THE SUBSTANCE USE HAS AFFECTED THE CLIENT'S LIFE. ************

Initial Intake continued….

- Since the initial intake is where medical necessity must first be documented, it incorporates **the six dimensions of the ASAM Criteria**. All of the above information is addressed in a standard intake, the ASAM assessment form as we go through each dimension. As we get to know our clients during the intake period, we should always keep in mind one thing…..

- **HOW DOES THIS RELATE TO SUBSTANCE USE?**

Initial Intake Required Components

- For SUD services, the initial intake that is completed upon the clients' admission to **treatment is where the documentation of Medical Necessity begins**. As with any standard intake, it is a compilation of information gathered from interviewing the client and, if applicable, with information from significant others that may be involved with the client's treatment or referral for treatment.
- Who can document? An LPHA or Counselor
- Timeframe? Treatment Plan is due within 30 calendar days from the client's admission to treatment.
- You **MUST** document all the symptoms to support a diagnosis.
- **Example:**

  Alcohol use disorder-we will need 6 or more DSM symptoms to support.

ASAM ASSESSMENT-The 6 Dimensions

- Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential
- Dimension 2: Biomedical Condition and Compliance
- Dimension 3: Emotional, Behavioral, and/or Cognitive Conditions and/or Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse and/or Continued Use Potential
- Dimension 6: Recovery/Living Environment

Initial Intake Required Components Continued/Connected to ASAM:

All of the information below that is addressed in a standard assessment will be addressed in the ASAM:

1. Drug or alcohol use history: ASAM dimension 1
2. Medical history: Dimension 2
3. Family history: Dimensions 1, 3, 6
4. Psychiatric/psychological history: Dimension 2
5. Social/Recreational history: Dimension 6
6. Financial Status/history: Dimension 4
7. Educational history: Dimension 6
8. Employment History: Dimensions 4, 6
9. Criminal History, legal status: Dimension 6
10. Previous SUD treatment history: Dimensions 4 and 5

HOW TO DOCUMENT THE CONNECTION BETWEEN SUBSTANCE USE AND THE IMPAIRMENT?

- **One suggestion is to use the following formula to ensure it is in your documentation**:

- "Due to client's _____(symptoms of SUD), client _____(behaviors) resulting in _____ (impairment)."
- This structure clearly demonstrates the connection between the substance use and the problem or impairment. It is important to remember that substance use alone cannot lead to the impairment or problem.
- For example:

  Susie may be drinking alcohol all throughout the day, but this fact alone does not lead to her job loss. Something occurred as a result of Susie drinking all day. Perhaps she was caught drinking at work. Another way to think is how actions lead to consequences.

Documentation of Substance Abuse and Impairment continued…

- These statements help to **concisely document how the client meets Medical Necessity and is most useful to use in the Rationale Section of each dimension of the ASAM Assessment form and the case formulation in which you summarize client's current needs and the recommended treatment.**

Treatment Plan

- Once the ASAM is completed, you now have the basis for building the clients' treatment plan.
- Who can document? LPHA or Counselor
- The treatment plan is the client's roadmap for his or her time in this current treatment episode. **Must be done 30 days from admission to treatment**.
- The risk ratings that are indicated for each dimension of the ASAM Assessment form will help you to identify and prioritize the areas that need to be addressed in treatment.
- If a client has a problem in EVERY dimension, this does not necessarily mean that every problem must be treated.
- **WE MUST take into account what is feasible for the client as well as the priorities for the client. In order to develop a meaningful treatment plan, the client must be involved. It is in the PROGRESS NOTE where you DOCUMENT as to why a particular area will or will not be addressed. That way nobody is guessing at what and why you are doing it. SPELL IT OUT.** ☺

Treatment Plan Required Components

- Problem statement (Primary Counselor is……) goes in this section
- Goals
- Action Steps (objectives)
- Target Dates (date the objective is to be completed by)
- Description of Services: type and frequency (no Ad Hoc)
- Assignment of Primary Counselor (In Addiction Problem Section)
- Beneficiary's Diagnosis
- Physical Examination Goals
- Significant Illness
- Must be updated no later than **90 calendar days after signing the initial treatment plan and no later than every 90 days thereafter OR ☺ whenever there is a change in problem identification or focus of treatment, whichever is first.**
- **For RESIDENTIAL-this is every 30 days**

Treatment Plan Continued…

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****WE MUST take into account what is feasible for the client as well as the priorities for the client. In order to develop a meaningful treatment plan, the client must be involved. It is in the PROGRESS NOTE where you DOCUMENT as to why a particular area will or will not be addressed. That way nobody is guessing at what and why you are doing it. SPELL IT OUT. ☺**

Problem on Treatment Plan

***This is based on the dimensions with the highest risk ratings that will need a goal on the treatment plan. AND MUST show Medical Necessity ***As done in the assessment.**

***Since treatment planning is a collaborative process with the client, it is important to explore with the client what problems he or she would like to resolve or what he or she is working to achieve. It is our job to work with the client on breaking it down to what has been identified as the key problems in the assessment process (I want to be a rock star, I want to be a king). ***

Timelines: Within 30 days from admission to treatment

Goal ******

- **The goal is broken down into what piece of the problem will be addressed in this treatment episode. SO, given the identified problem that corresponds to the dimensions of the ASAM Assessment form, we will want to determine**

"What do we need to work on first to get you where you want to be?"

Objectives

MUST be measureable ******

- Sally May will attend at least 2 self-help meetings a week and submit verification of attendance to Primary Counselor during her individual sessions as evidenced by providing signed self-help sheet.
- Over the next 90 days, Susie will attend assigned treatment groups and individual counseling sessions. She will focus on the development and use of a Relapse Prevention Plan. Client will increase her ability to remain sober as evidenced by: Client will verbalize at least 3 new coping skills that will assist her to prevent relapse and will have no positive tests.

Physical Examination

- **Physical Examinations—NO WAIVERS PERMITTED DMC requires that all clients have a documented physical examination.**
- All clients must have had a physical examination within the twelve-month period prior to admission to treatment.
- If documentation of a physical examination cannot be obtained, providers must describe in the client record efforts taken to obtain documentation.
- If a client had a physical exam within twelve months prior to treatment admission, a physician must review the exam within 30 calendar days of the admission date to determine if the client has any significant medical illnesses.
- A copy of the physical exam must be included in the client record. Treatment Plans must incorporate any relevant findings from the physical examination that need to be addressed or followed up. **Thus all ASAM documentation must have at least MILD in Dimension 2-Bio Medical Conditions to capture this and it must be on the treatment plan as an objective to address.**

Physical Examination continued…

- Remember, all ASAM assessments must have at least a mild to transfer to the treatment plan.
- Physical Health will be a problem, goal and objective for the client on the treatment plan.
- Client must obtain a physical exam within the first 30 days and bring in proof of this exam
  - **Problem:** Client preventative action for health has been neglected and physical health issues have been exacerbated by client's ongoing substance use.
  - **Goal:** Client will obtain a physical health exam within the next 30 days.
  - **Objective:** Client will identify and make a primary care appointment to obtain physical exam as evidenced by client bringing back proof of the exam from the physician.
- If client does not within the first 30 days, continue to document your efforts to assist client with this.

Interventions

- ✓ **MUST** indicate type of counseling and frequency of the service
- ✓ **MUST** indicate the type of staff that will be completing the service
- ✓ **MUST** contain Evidenced Based Practice interventions (CBT, Motivational Interviewing, Trauma-Informed, MRT, etc.)

Example**:**

Program Planning: Bert will meet with primary AOD Counselor once per month to review progress toward completion of treatment plan goals and objectives.

Individual Counseling (Substance Abuse): Counselor will utilize Trauma informed treatment as well as Motivational Interviewing in working with this client.

Progress Notes

- We are using the BIRP format
- **B-Behavior**: counselor observation, client statements
  1. Subjective data about the client-what are the client's observations, thoughts, direct quotes?
  2. Objective data about the client-what does the counselor observe during the session (mood, appearance, affect)?
- **I-Intervention:** Counselors methods used to address goals and objectives, observation, client statements. **Evidenced based methods must be noted**.
  1. What goals and objectives were addressed this session?
  2. Was homework reviewed?

Progress Notes continued….

- **R-Response:** Client's response to the intervention and progress made toward treatment plan goals and objectives.
  1. What is the client's current response to the clinician's intervention in the session?
  2. Client's progress attending to goals and objectives outside of the session?
- **P-Plan:** Document what is going to happen next.
  1. What in the Treatment Plan needs revision?
  2. What is the clinician going to do next? What will client do next?
  3. What is the next session date?

Progress Notes continued…

- **NOTE: <u>you do not need to put everything</u> that happened in the session in the note. We want to protect privacy and confidentiality. It is about QUALITY and not QUANTITY. Primary purpose is to document the service provided. Tie it back to the substance use and effectively show how the service is necessary to address this. Medical Necessity MUST*** be evident.**
- **Ensure that your notes demonstrate impairment/s still needing to be addressed.**

This will help notes stay clear and concise ☺

Progress Note Example: BIRP format

- **B**: Client came to session today disheveled, made poor eye contact and stated she had been triggered over the weekend but did not use. Mood appeared dysphoric and affect was flat.

- **I**: Writer reviewed with client what had taken place over the weekend using Motivational interviewing skills. Supported client in her ability to make the choice not to use and discovered client has some safe people in her life that she has never been able to identify before. Client is working toward building a healthy support system as one of her goals on her treatment plan. We reviewed this goal and made the connection of what had taken place over weekend.

BIRP Note Continued…

- **R**: Client's mood did change as the session progressed. She was able to make the connection but still appears to be ambivalent about counting on anyone due to her history and trauma she has experienced. Client would like to keep this as a goal and continue to work within the treatment program to also find other support people.

- **P**: Plan at this point with client is that she has the homework assignment of identifying at least one person at the program as someone she can call when feeling triggered. We will meet again in one week on October 23, 2018 at 2 pm. We will continue to monitor treatment plan and ASAM level of care.

Other Components of a Progress Note

- Notes, according to BHRS, must be completed and signed within 3 calendar days of the session. Date of the session counts as Day 1.
- **Face to face time is time with the client, in person**. If session or service was provided by phone, there would be no face to face time.
- **Non Face to Face time is billable time spent on a service activity** that does not include interaction with the client. Example: Analyzing information to determine risk rating level for the dimensions of the ASAM Criteria outside of the session with the client.
- Service Time is total time (face to face and/or non face to face, travel and documentation)

Title 22 Criteria for Group Sign in Sheets

- ***A sign in sheet is required for every group counseling session***
  - ***The name of the server populated at the top of the page (staff assigned to facilitate the group)***
  - ***should match the name of the person signing and writing their name at the bottom of the page***
  - ***If covering another group, you MUST make sure the sign in sheet is printed with your name as facilitator***
- ***The sign in sheet must include the:***
  - ***date (complete with the day, month, year)***
  - ***start and end time of each group session***
  - ***Topic/Group Name***
  - ***(BHRS only) Reminder, the end time does not print on our log, therefore you MUST manually write this on the page where the time is captured.***

Title 22 Criteria for Group Sign in Sheets continued…

- **ON top of the page it must include the topic of the group session (not just the name of the groups, such as MRT but the actual topic of that group's session that was covered with participants.**
- **The AOD Counselor/Clinician MUST type of legibly print name and sign. NEW: ON the bottom of the group log, where you typically sign and enter your server number, ADJACENT to your signature, you now MUST PRINT your name. Even though your name populates at the top of the form, you must PRINT and SIGN your name on the bottom of the page, adjacent to one another. This is a new State requirement, so please make sure you include both of these components.**
- **The Sign in Sheet Must include typed or legibly printed participant names AND signatures. (both are needed) If a client signs manually, they must print their name in the box as well.**

Title 22 Criteria for Group Sign in Sheets continued…

- **Do not use pencils or markers or colored pens for signature.**
- **IF you make corrections, strike a line through what is corrected, initial and date.**
- **What was corrected should still show through the line.**

Group Progress Notes

- **You will enter Group #, Name, Curriculum, Week, Module, Session, Topic etc.**
- **Overview Narratives**
- **Consumer Narratives**
- **Linked Objectives (back to the treatment plan)**

Outpatient Group Progress Note Example:

- **<u>Overview/Narratives:</u>**
- **Counselor facilitated a discussion with the group regarding triggers and encouraged the group to identify emotional and situational factors that affect their desire to use. The counselor assisted group members in identifying triggers and ways to cope, such as social support, relaxation skills, and change of environment.**

Outpatient Consumer Narrative

- When the client participated in group, he appeared withdrawn and guarded. He was able to engage in the group process with the help of the counselor and reported having difficulties with triggers, saying, “that’s why I never stopped using.” Patient reported being fearful of relapse due to strong cravings, but stated “I feel better being on Suboxone, it makes the cravings more manageable.” Client identified two triggers:, “seeing the scars from my accident” and “being around other people that use stuff.”

Outpatient Linked Objectives

The Group Progress Note should Link to the Related Objectives on the Treatment plan.

What are Evidenced Based Practices? Key Principles of a Trauma-Informed Evidence Based Approach

- Safety
- Trustworthiness and Transparency
- Collaboration and mutuality
- Empowerment
- Voice and Choice
- Peer Support and Mutual self-help
- Resilience and strength
- Inclusiveness and Shared Purpose
- Cultural, historical and gender issues
- Change Process

10 Principles of Trauma-informed Programs (Evidence Based)

1. Recognize the impact of trauma
2. Recovery is the primary goal
3. Employ an empowerment model
4. Emphasize choice
5. Stress relational collaboration
6. Recognize the need for safety and respect
7. Emphasize strength and resilience
8. Minimize re-traumatization
9. Cultural competence
10. Wide input

Evidence Based Sample MI Interview Questions

What are the good things about using...?

What are the not so good things about using…?

What are the good things about stopping...?

In looking over the not so good things about stopping ...?

In looking over the good and not so good aspects of your alcohol/drug use, what do you notice…?

What benefits seem most important to you…?

Which of the not so good things do you think cause the most problems for you?

If we could come up with healthier ways for you to get these same benefits, do you think it might be easier for you to cut down on your use...?

On a scale of 1-10, how ready are you to start working on these things?

Documentation Time and Travel Time

- Time it took to complete the progress note
- This should never exceed the length of the session and should correspond to what is reasonable in comparison to the interventions provided. This does not include typing or writing speed. It also does not include technical difficulties. If the computer freezes and it took 10 minutes to restart and get back to the note, this cannot be accounted for.
- **Travel time** is the time it takes to travel from one location to another to meet with a client or provide a service.
- Transporting a client does not count for this. **IF solely transporting** a client from point A to point B, this time is **non-billable to Medi-Cal**. However, if during the course of transporting the client from point A to B, some billable service is provided (such as discussing recent response to triggers and use of coping skills) this is considered Service Time because you provided a service.

Stay Review ****

- **Must** be completed before 6 months but not before 5 months.
- There will need to be an updated ASAM assessment, treatment plan review and update. This will provide guidance on what changes, if any, need to be made on the clients' treatment plan. The primary counselor and the client will work together to review progress and discuss whether the goals are still relevant or if modifications are needed.
- A Stay Review form must be completed.
- For example: If no progress made on a goal, perhaps the frequency needs to be changed, interventions modified, and target dates re-set. Or it may be more appropriate to create a whole new goal.
- **WE MUST show that the client's needs were reassessed and that appropriate changes were made in collaboration with the client. Spell it out so nobody is guessing at what you are doing and why. Leave no one in the dark ☺**

Discharge Planning

- Begins at Intake. You begin to lay the groundwork for eventual discharge and possible Aftercare.
- Discharge plan is required for planned discharges (Within 30 day of last face to face service)
- Required Elements: List of relapse triggers
- Plan for avoiding relapse when faced with triggers
- Support Plan: people, organization
- During last face to face, LPHA/counselor and client shall type or legibly print their names, sign and date the plan.
- A copy must be provided to the client
- This must be documented

Discharge Planning Continued…

- Discharge summary is required for an unexpected lapse in treatment services for 30+ days
- Completed by LPHA/Counselor within 30 days of last face-to-face
- **Required Elements:**
  - Duration of treatment episode
  - Reason for discharge
  - Narrative summary of the treatment episode
  - Prognosis

After Care/Recovery and Peer Support Staff

Although the timeline for rehab or any formal treatment duration will vary, at some point this phase of recovery will approach an end point.

Ongoing recovery efforts, however, are likely and encouraged to continue.

This is where diligent aftercare planning becomes important. Substance abuse treatment programs that make lasting recovery a priority will not send program participants on their way without a solid discharge plan and connecting them with quality aftercare programs.

After Care/Recovery

- "Aftercare" is a general term used to describe any ongoing or follow-up treatment for substance abuse that occurs after an initial rehab program. No matter the setting, treatment provider, or methods used, the goals of addiction aftercare programs are the same and include:
  - To maintain recovery from substance abuse.
  - To find ways to prevent relapse.
  - To achieve a life filled with rewarding relationships and a sense of purpose.
  - One reason that continuing treatment is essential in all situations is because longstanding substance abuse can, in some cases, alter the normal functioning of the brain. Some of these changes do not instantly reverse once use ends. In fact, they can last long after substance use has terminated.

Aftercare/Recovery continued…

- The physical impact of addiction is often accompanied by several psychological changes—affecting thoughts, feelings, and behaviors that may persist even after the substance is removed from the body. The physiological changes associated with addiction and their potential lasting impacting to both mental and physical health serve to reaffirm the need for long-term treatment

WRAP UP ☺*******

- Questions??
- Concerns??